STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING 00			COMPLETED	
		155711	B. WIN			09/16/2	011	
NAME OF F	PROVIDER OR SUPPLIER		-	1	ADDRESS, CITY, STATE, ZIP CODE			
					ORTH CAPITOL AVENUE			
HIGHLAN	ND MANOR HEALT	HCARE		INDIAN	IAPOLIS, IN46208			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0000								
	This visit was for	r a Recertification and	FO	000				
			10	000				
		Survey. This visit						
		estigation of Complaint						
	11NUUU93694 and 	Complaint IN00095779.						
	G 1: DIO	007704						
	_	095694 unsubstantiated						
	due to lack of ev	idence.						
	G 1:							
	*	095779 substantiated no						
		ated to the allegations are						
	cited.							
	Survey dates: Se	eptember 12, 13, 14, 15,						
	16, 2011							
	Facility number							
	Provider number	:: 155711						
	AIM number:	100289560						
	Survey team:							
	Connie Landmar	n RN TC						
	Diana Zgonc RN	I						
	Christi Davidson	ı RN						
	Courtney Hamilt	ton RN						
	Census bed type:	· ·						
	SNF: 3							
	NF: 14							
	SNF/NF: 26							
	Total: 43							
	Census payor typ	oe:						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

862411

Facility ID:

000567

If continuation sheet

l		IDENTIFICATION NUMBER: 155711	(X2) MULTIPLE A. BUILDING B. WING	00		ESURVEY PLETED 2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
	Medicaid: 3 Medicaid: 40 Total: 43							
	Sample: 25							
		es also reflect state dance with 410 IAC 16.2.						
	Quality review co Cathy Emswiller							

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIM DD		00	COMPL	ETED
		155711	A. BUILDIN B. WING	u		09/16/2	011
				DEETA	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
HIGHLAN	ID MANOR HEALT	HCARE			ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
F0156	•	nform the resident both					
SS=E	•	g in a language that the					
		nds of his or her rights and					
		ations governing resident					
	·	onsibilities during the stay in					
		cility must also provide the otice (if any) of the State					
		§1919(e)(6) of the Act. Such					
		e made prior to or upon					
		ring the resident's stay.					
		formation, and any					
	amendments to it,	must be acknowledged in					
	writing.						
	•	nform each resident who is					
		d benefits, in writing, at the					
		to the nursing facility or,					
		becomes eligible for ems and services that are					
		g facility services under the					
		which the resident may not					
	•	other items and services					
	-	ers and for which the					
		harged, and the amount of					
	charges for those	services; and inform each					
	resident when cha	nges are made to the items					
		ified in paragraphs (5)(i)(A)					
	and (B) of this sec	tion.					
	The feeilite	sforms and maridant buffers					
	-	nform each resident before,					
		dmission, and periodically t's stay, of services					
	•	cility and of charges for					
		cluding any charges for					
		ed under Medicare or by					
	the facility's per di						
	, ,						
	The facility must fu	urnish a written description					
	of legal rights which						
A description of the manner of protecting							
	•	nder paragraph (c) of this					
	section;						

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 09/16/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	procedures for esi Medicaid, includin assessment unde determines the ex non-exempt resour institutionalization community spousi resources which cavailable for payminstitutionalized spor her process of eligibility levels. A posting of name telephone number advocacy groups and certification a office, the State or protection and advice the State survey and concerning reside misappropriation of facility, and non-ordirectives requirements spec of this chapter relapolicies and procedirectives. These provisions to information to all at the right to accept surgical treatment option, formulate a includes a written	and attributes to the ean equitable share of cannot be considered tent toward the cost of the couse's medical care in his spending down to Medicaid as, addresses, and as of all pertinent State client such as the State survey gency, the State licensure inbudsman program, the vocacy network, and the introl unit; and a statement may file a complaint with the certification agency in abuse, neglect, and of resident property in the compliance with the advance ments. I comply with the cified in subpart I of part 489 ated to maintaining written adures regarding advance requirements include in and provide written adult residents concerning or refuse medical or and, at the individual's an advance directive. This description of the facility's ent advance directives and						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/16/2011		
	PROVIDER OR SUPPLIER		STREET A 2926 N	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE IAPOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	.N
	name, specialty, a physician response. The facility must pfacility written information residents and appeand written informand use Medicare how to receive refcovered by such be Based on intervito ensure Medicare bene exhausted for a reviewed for M letters in a Stag (Resident # 36). Findings include During an interval Administrator of the Medicare derequested for retat time the letatone. He state	view the facility failed care discharge letters sident's whose fits had been 8 of 3 residents edicare discharge ge 2 Sample of 25 , # 27 and # 55). e: view with the on 9/15/11 at 2:00 P.M., ischarge records were eview. He indicated at ters had not been ed, "We didn't realize k survey they were not	F0156	All residents have the poter be affected. Residents will treviewed during weekly Medicare/Therapy meeting determine if a change in set is anticipated and if a Medic discharge notice is required Identified residents will have appropriate Medicare Disch letter selected and produce the Social Services Director Social Services Director will resident with letter and appropriate signatory of understanding. MDS and Sc Services Director are responsible. Administrator, Executive Director, and DO monitor for compliance. Compliance will be evaluate weekly 3x and then quarterl by QA. Completed 9/26/11 and on-going.	to rvice care . e the arge d by . notify Decial N will ed y 3x	111

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER			2926 N	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F0224 SS=G	written policies and mistreatment, neg and misappropriat Based on obse and interview the ensure a reside harm while recoresulting in the pain and discor of 25 residents in a stage 2 sar #26) 1. Resident #26 reviewed on 09 Diagnoses including the left at amputation, del (cerebrovascula (hypertension), agitation, and particular dated 05/17/11 #26 had a BIMS mental status) secognitive impair ambulate, and on staff for local eating, toileting	resident experiencing infort. This affected 1 reviewed for pericare imple of 25. (Resident in 18.5) is record was 1/14/11 at 9:25 A.M and an accident), HTN dementia with esychosis. The Data Set (MDS), indicated resident in 18.5 (brief interview for inscore of 6 (severe in 19.5), information in 18.5 (severe in 18.5) i	F0	224	All residents have the poten be affected. Nursing staff have the perison peri-care with clear emphas identifying when care become abusive. One on One perison in-service conducted and repeated to define when to scare admin and acknowledge resident comfort. Abuse in-service conducted to more clearly define when and how can become abusive. Care (routine and peri) is monitor nurses. Skills forms are availed for use during care observation identify areas of re-training a redirection. Charge nurses responsible for observing/traduring daily care. Skills performances monitoring care/abuse will be reviewed monthly 3x and hen quarterly in QA. Peri-care in-service completed 9/23/2011. Abuse/Neglect in-service completed 9/23/1011. Charnurses are responsible. DO monitor on rounds and reviewskills forms. Completed 9/23, and ongoing.	as of is n nes estop e e / care ed by uilable ion to and are aining y 3x ge N will w of	09/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155711	B. WIN			09/16/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	'	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUFFLIER			2926 N	ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALT	HCARE		INDIAN	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
	` -	n) limitation on both					
	sides of his upp	per and lower					
	extremities.						
		plan dated 08/31/11,					
		ent #26 had a Foley					
		as dependent for ADL's					
	l ,	ily living), bathing,					
		grooming. The care					
	l '	the resident was					
		owel. The care plan					
		resident #26 had					
		his left hand and left					
	elbow and a re	ctai iistuia.					
	During an obse	ervation of pericare on					
		40 A.M., CNA #2,					
		rs off of Resident #26.					
	Resident was r	nude under the covers.					
	CNA #2 roughly	y grabbed the					
		cles and started					
	roughly washin	g them using a wet					
	• •	th. Resident #26's					
	testicles were v	ery red and					
	excoriated. As	CNA #2 washed the					
	testicles, the re	sident started yelling,					
	"ouch your hu	urting my					
		at hurts." CNA #2					
	responded by s	saying, "sorry, but I					
	gotta clean this	". The CNA then					
	grabbed Reside	ent #26's penis and					
	again started ro	oughly washing the					
	penis and the F	Foley catheter. The					
	resident yelled	out, " stop ouch your					
	hurting my pete	erouch!". The CNA					

	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711		LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		•	2926 NO	DDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE APOLIS, IN46208	•	
				<u> </u>			ars)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
-		ed by saying "sorry, I	1	_			
		an this". The CNA did					
	. •	g the resident nor did					
		amount of force she					
		n the resident stated					
		. CNA #2 then rolled					
		over. The resident had					
	a bowel mover	nent and some stool					
	was sitting in h	is rectal fistula. His					
	buttocks were	excoriated. CNA #2					
	used a dry tow	el and started wiping					
	Resident #26's	buttocks and rectal					
	area. The resid	lent started yelling,					
	"ouch that hurt	syou know I have					
	hemorrhoids st	topouchouchmy					
	hemorrhoids!".	CNA #2 responded by					
	, , , ,	on't have hemorrhoids					
	you have a wo	und" There was stool					
		ectal fistula. Again, the					
		duce the amount of					
		amount of force she					
	_	n the resident stated					
		. The CNA turned the					
		n to his back. He was					
		osed. The resident					
	· ·	d, cover me up." The					
		l cover you up when I'm					
	finished with yo						
		esident #26 and then					
	•	hcloth to place in his hand. CNA #2 told the					
		nand. CNA #2 told the ix and started to push					
		into the resident's					
		dent began to yell, "you					
		ouch ouch ouch					
	l are killing line	ouch ouch ouch					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155711	B. WIN		-	09/16/2	011
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	3		1	ORTH CAPITOL AVENUE		
HIGHI AI	ND MANOR HEALT	HCARE		1	APOLIS, IN46208		
					Al OLIO, 11440200		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	ouchstop	•					
	mestop!" The	e CNA told the resident					
	if he relaxed it	wouldn't hurt as much					
	as she continu	ed to push the					
	washcloth into	his hand. The resident					
	yelled again. ".	stopyou know I					
	, ·	thritis)ouch ouch"					
	,	ied to reach up with his					
		d stop the CNA but					
		n her. The CNA did not					
		ashcloth was in his					
	l '						
		dent indicated his hand					
		NA responded, "its					
	-	or a little bit." The CNA					
		t nude and then					
	covered the re-	sident up and left the					
	room.						
	An interview w	ith CNA #2 on 09/14/11					
	at 12:15 P.M	indicated she had gone					
		oom and place barrier					
		esident's testicles. The					
		, the resident always					
		•					
		nat during pericare. She					
	1	ust tell him to relax, like					
	1	as putting the washcloth					
	in his hand"						
		ted facility policy titled,					
	"Abuse and Ne	eglect' provided by the					
	1	ctor on 09/14/11 at					
		dicated, "Abuse: the					
	· ·	of injury, unreasonable					
	confinement, ir						
	•	·					
	F barnstittient Mi	th resulting physical					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155711	B. WING		09/16/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
HIGHLAN	ND MANOR HEALT	HCARE	I	ORTH CAPITOL AVENUE APOLIS, IN46208	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	harm, pain or mental anguish"				
	"Abuse Protect the Executive I 12:23 P.M., ind of this facility to all abusive acts staff member, values a reside an abusive situ the abuse of a immediate dismember suspe	ted facility policy title, ion Policy" provided by Director on 09/14/11 at icated "It is the policy protect residents from s" Procedure: 7. Any who intentionally ent or permits to exist ation which results in resident, is subject to hissal. Any staff cted of abuse will be ding the investigation on"			
F0241 SS=G	The facility must pa manner and in a maintains or enha and respect in full individuality. Based on observatinterview, the facil resident's dignity opericare, while in the dining room during 3 of 25 residents in the manner of the second sec	romote care for residents in n environment that nces each resident's dignity recognition of his or her tion, record review and ity failed to ensure was preserved during he restroom and in the g meal times. This affected eviewed for dignity in stage tesidents #26, 29, 69)	F0241	All residents have the potent be affected. Same as in F 224 Nursing staff has been re-tra on provision of peri-care with clear emphasis n identifying care becomes abusive. One One peri-care in-service conducted and repeated to d when to stop care admin and acknowledge resident comfo	4. ined n when on define

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155711 09/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2926 NORTH CAPITOL AVENUE HIGHLAND MANOR HEALTHCARE INDIANAPOLIS, IN46208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Abuse in-service conducted to 1. Resident #26's record was reviewed on more clearly define when and 09/14/11 at 9:25 A.M.. Diagnoses included but how care can become abusive. were not limited to left above the knee Care (routine and peri) is amputation, debility, CVA (stroke), HTN monitored by nurses. Skills forms (hypertension), dementia with agitation, and are available for use during care psychosis. observation to identify areas of re-training and redirection. A current Minimum Data Set (MDS) dated Charge nurses are responsible 05/17/11, indicated resident had a BIMS score for observing/training during daily of 6. did not ambulate, and was totally care. Skills performances dependent on staff for locomotion, dressing. monitoring care/abuse will be eating, toileting, personal hygiene and bed reviewed monthly 3x and hen mobility. Resident had ROM (range of motion) quarterly 3x in QA. Peri-care limitation on both sides of his upper and lower in-service completed 9/23/2011. extremities. Abuse/Neglect in-service completed 9/23/1011. Charge A current care plan dated 08/31/11, indicated nurses are responsible. DON will resident had a Foley catheter and was monitor on rounds and review of dependent for ADL's (activities of daily living), skills forms. Completed 9/23/11 bathing, dressing, and grooming. The care and ongoing. Dignity inservice plan indicated the resident was incontinent of done 9/23/11. Additionally a bowel. The care plan also indicated resident "Care Instruction Sheet" has been had contractures of his left hand and left completed on each resident to elbow and a rectal fistula. include indentified specific needs once staff aware. Nurse aides During an observation of pericare on 09/14/11 are aware of the location of these at 10:40 A.M., CNA #2, pulled the covers off sheets and the purpose. They of Resident #26. Resident was nude under are also aware that they can add the covers. CNA #2 roughly grabbed the info re: the resident also. resident's testicles and started roughly Resident interviews have been washing them using a wet soapy washcloth. previously conducted and will Resident #26's testicles were very red and continue monthly to aid in excoriated. As CNA #2 washed the testicles, identifying needs/concerns. Identified areas will be addressed the resident started yelling, "...ouch your hurting my balls...stop...that hurts." CNA #2 on "Care Instruction Sheet" responded by saying, "sorry, but I gotta clean and/or individual care plans. All this". The CNA then grabbed Resident #26's department heads are penis and again started roughly washing the responsible for gathering penis and the Foley catheter. The resident information and individual yelled out, " stop... ouch your hurting my departments are responsible for peter...ouch!". The CNA again responded by implementing changes as

862411

l i '		(X2) M	ULTIPLE CON	NSTRUCTION		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00		COMPL	ETED
		155711		LDING	-	_	09/16/2	011 l
			B. WIN					
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP C			
				2926 NC	ORTH CAPITOL AVENU	JE		
HIGHLAN	ND MANOR HEALTI	HCARE		INDIANA	APOLIS, IN46208			
(X4) ID	SUMMARV S	TATEMENT OF DEFICIENCIES		ID				(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S	RRECTION SHOULD BE		COMPLETION
TAG	*			TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIAT	E	DATE
IAG		LSC IDENTIFYING INFORMATION)		IAG				DATE
		ve got to clean this". The			indentified. Executiv			
	•	rubbing the resident nor did			Administrator, DON			
		nount of force she was using			on review and walkir	•		
		stated he was in pain. CNA			Findings and recomr			
		sident #26 over. The			will be reviewed mor	nthly 3x a	and	
		wel movement and some			then quarterly 3x in			
		his rectal fistula. His			QA. Completed 9/26	/11 and		
		oriated. CNA #2 used a dry			on-going.			
		wiping Resident #26's						
		al area. The resident started						
		hurtsyou know I have						
	hemorrhoids stop.	<u> </u>						
		IA #2 responded by saying,						
	•	emorrhoids you have a						
		as stool visible in the rectal						
	fistula. Again, the	CNA did not reduce the						
		or the amount of force she						
	was using when th	ne resident stated he was in						
	pain. The CNA turi	ned the resident over on to						
	his back. He was o	completely exposed. The						
	resident stated, "I'ı	m cold, cover me up." The						
	CNA stated, "Ill co	ver you up when I'm						
	finished with you."	The CNA repositioned						
	Resident #26 and	then grabbed a washcloth						
	to place in his con	tracted left hand. CNA #2						
	told the resident to	relax and started to push						
		the resident's hand. The						
	resident began to	yell, "you are killing						
		uch ouchstop you are						
	killing mestop!"	The CNA told the resident if						
		dn't hurt as much as she						
	continued to push	the washcloth into his hand.						
	The resident yelled	d again, "stopyou know I						
		tis)ouch ouch" The						
	,	each up with his other hand						
		but could not reach her.						
		stop until the washcloth was						
		esident indicated his hand						
		responded, "its going to						
		The CNA then covered the						
	resident up and let							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	862411	Facility II	D: 000567 If cor	ntinuation sh	neet Pa	ge 12 of 45

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155711	B. WIN			09/16/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ORTH CAPITOL AVENUE		
LIICHIAN		HCADE					
HIGHLAI	ND MANOR HEALT	HOARE		INDIAN	IAPOLIS, IN46208		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		CNA #2 on 09/14/11 at					
		ited she had gone back into					
		ce barrier cream on the					
		s. The CNA indicated, the					
	1	creams like that during cated, "I just tell him to					
		en I was putting the					
	washcloth in his h						
	2. The record	for Resident #69 was					
		9/14/11 at 8:50 a.m.					
	Teviewed on oa	7/14/11 at 0.50 a.m.					
	D'	and all back are seek					
	•	uded, but were not					
		ar disorder, auditory					
	hallucinations,	high cholesterol,					
	anxiety, agitation	on, schizoaffective					
	disorder, uncor	ntrolled diabetes					
	· ·	and legally blind in the					
	right eye.	and regard similarity					
	l light eye.						
	A	Airing Data Oat					
		Minimum Data Set					
	` ′	ment dated 08/25/11,					
	indicated Resid	dent #69 had severely					
	impaired vision	. The MDS indicated					
	Resident #69 v	vas able to recall all					
		ven in assessment and					
		year, month and day					
	of the week.	, your, month and day					
	OI LITE WEEK.						
	A secretarity						
		sessment dated					
	08/19/11 indica	ited, "Feeds self in					
	MDR [main din	ing room]"					
	A Social Service	e Progress Note dated					
	08/24/11 at 17:	•					
		tates that she is					
	mulcateu,o						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		D.C.	00	COMPL	ETED
		155711	A. BUILD	ING	- <u></u> -	09/16/2	011
			B. WING	CED FEE A	DDDEGG CUTY GTATE TIP CODE		
NAME OF I	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ORTH CAPITOL AVENUE		
HIGHLA	HIGHLAND MANOR HEALTHCARE			INDIAN	APOLIS, IN46208		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	<u> </u>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	spoken to rude	elyBecame tearful at					
		bal aboutlikes and					
	dislikes"						
	A care plan dated	l 08/25/11 indicated,					
		ntswould be better off dead					
		new situation. Has no plan					
		make no attempt to harm					
	selfIntervention	sAttempt to be available to					
	resident when she	e wants to talkEncourage					
		the thingsis able to do and					
	praise efforts"						
	 D	00/40/44 4.57					
		ew on 09/12/11 at 1:57 p.m.,					
		icated, "They don't always with me, like at the table."					
		icated she did not want help					
		n during meal times with					
	_	lice cartons and opening					
		nt #69 indicated, "They want					
		I I say no I can do this."					
	_	ation and interview on					
		p.m., Resident #69 was					
		sident #69 indicated the staff					
	•	milk for her. She indicated					
		to remind them she does not					
	need help.						
	During an intervie	ew on 09/15/11 at 10:21 a.m.,					
		icated this morning at					
		s having difficulty opening					
		nd another resident brought it					
		Resident #69 indicated a					
		ne over and opened the milk					
		was in the process of doing					
		ndicated, "I don't know what					
		on't know if they have ever					
	•	t can't see very well."					
		icated she feels "helpless."					
	Kesident #69 indi	icated, "I didn't know what to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MULTIPLE A. BUILDING B. WING	00	(X3) DATE COMP 09/16/2	LETED			
	PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE					
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES	ID PREFIX	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION		
TAG	say or what to do.	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		
	CNA #3 indicated members set-up F main dining room. opening things up	w on 09/15/11 at 2:52 p.m., I she has seen other staff Resident #69's tray in the "They are so used to just ." for Resident # 29 was 15/11 at 9:05 A.M.						
	but were not lin Lateral Scleros Urinary Retenti Hypertension, Benign Prostat Anxiety, bladde Coronary Arter	Dementia, Depression, ic Hypertrophy, pain,						
	(Minimum Data dated 6/30/11 i							
	indicated a Fall Ri inability to use his of a diagnoses of A Social Service r the resident had n	Care originally dated 4/8/11 sk due to decreased upper extremities because ALS. note dated 6/29/11 indicated to use of his arms and ly dependent on staff for his						
	care.							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155711	B. WING		09/16/2011
NAME OF P	PROVIDER OR SUPPLIER	= L		ADDRESS, CITY, STATE, ZIP CODE	-
			l l	IORTH CAPITOL AVENUE	
HIGHLAN	ND MANOR HEALT	HCARE	INDIAN	NAPOLIS, IN46208	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	RIATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		w with the resident on .M., he indicated the staff			
		vith dignity and respect, they			
		e on the toilet, then leave			
	and don't come ba	ack. "I have to holler to get			
		on because they don't give			
		the call light and they know			
	I can't reach it." Observation at the	at time of the resident and			
		nroom indicated he was			
	unable to move hi				
	•	and the call light cord in the			
	bathroom was on	the left side.			
	During an interview	w with the Director of			
		1 at 4:30 P.M., she indicated			
	•	not supposed to be left alone			
	in the bathroom.				
	3.1-3(t)				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155711 09/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2926 NORTH CAPITOL AVENUE HIGHLAND MANOR HEALTHCARE INDIANAPOLIS, IN46208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE A facility must use the results of the F0279 assessment to develop, review and revise the SS=E resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical. mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). All residents have the potential to F0279 09/26/2011 be affected. Care plans have Based on record review and interview, the been reviewed for all residents facility failed to ensure care plans were with participation of all care givers developed and followed for 4 of 25 residents to identify reviewed in a Stage 2 sample of 25 needs/concerns/problems in an (Residents #6, #30, #71, and #69). effort to have a complete and accurate POC for each resident. Findings include: Changes in MD orders are reviewed daily by DON for 1. The record for Resident #6 was reviewed problems requiring update on on 9/15/11 at 9:40 A.M. POC for specified residents. MDS coordinator will initiate care Current diagnoses included, but were not plan on admission identifying two limited to, splenic rupture, GERD problems then gernerate (gastroesophageal reflux disease), additional from triggered items on esophagitus, anemia of chronic disease, MDS. Information from resident depression, right hip internally rotated, interviews is also incorporated in shortened, history of right hip the POC as indicated. All surgery,insomnia, muscle spasms,dysphagia, disciplines are responsible. DON poor intake, history of anoxic brain injury, and monitors updates during review of DVT (deep vein thrombosis). new MD orders daily and weekly

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155711	B. WIN			09/16/2	011
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ORTH CAPITOL AVENUE		
нісні лі	ND MANOR HEALT	HCADE			APOLIS, IN46208		
					Al OLIO, 11 4- 0200		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	orders indicated a Santyl to the esch be applied daily. indicated Warfarin (milligrams) was to the original care pand they were lass. The record lacked black eschar, 4.6 present on admission measured as 2.0 lively skin report.	plans were dated 6/3/11, treviewed on 7/28/11. I a care plan for an area of cm (centimeters) by 3.0 cm sion, 6/3/11, and currently by 2.0 cm. noted on the			in care plan conferences with individual residents. Review monthly 3x then quarterly 3x QA. Completed 9/26/11 and on-going.		
	on 9 /14/11 at 9:09 Current diagnoses limited to, traumat schizophrenia, atc retardation). HTN constipation, hypocapus and The current recap orders indicated F 100 ml (milliliters) the G/T (gastrostotal).	s included, but were not cic subdural hematoma, ony of bladder, MR (mental (hypertension), othyroidism, dyslipidemia,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	INC	00	COMPL	ETED
		155711	B. WING	UNU		09/16/2	011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ORTH CAPITOL AVENUE		
	ND MANOR HEALT	HCADE			APOLIS, IN46208		
HIGHLA	ND WANOR HEALT	HOARE		INDIAN	AFOLIS, 11140208		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		w with LPN #4 on 9/15/11 at					
	· ·	dicated there was no care					
	plan for her G/T with the rest of the care plans.						
		Resident #71 was reviewed					
	on 9/15/11 at 12:3	30 P.M.					
	Current diagnose	es included, but were not					
		ctomy, osteomylitis lower					
	•	Diabetes Mellitus), left upper					
	extremity fistula.	Diabotos Momtas), ion appoi					
	_						
		d 8/17/11, indicated a					
		sis". Interventions included,					
		ed to, assess weight pre/post					
		/P (blood pressure), and					
		n dialysis for needed					
	documentation re	garding run.					
	The Nurses Notes	s indicated Resident #71					
		n 8/30/11, 9/1/11, 9/8/11,					
		and 9/15/11. The record					
		ation of pre/post dialysis					
		cumentation from the					
	dialysis center, or	that he had returned from					
	dialysis.						
	Duning or leter !						
	_	w with LPN #4 on 9/16/11 at					
		ndicated the dialysis center ny paper work back with him.					
	nau never sent ar	iy paper work back with hint.					
	4 The record	for Resident #69 was					
		9/14/11 at 8:50 a.m.					
	i reviewed on os	<i>σ</i> , 1 -7 , 11 αι 0.50 α.111.					
	Diagnosas is al	udad butware set					
	1 ~	uded, but were not					
	•	ar disorder, auditory					
	•	high cholesterol,					
	anxiety, agitation	on, schizoaffective					
	disorder, uncor	ntrolled diabetes					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711		(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 09/16/2	ETED	
	PROVIDER OR SUPPLIEF		25	926 NC	DDRESS, CITY, STATE, ZIP CODE DRTH CAPITOL AVENUE APOLIS, IN46208	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	II PRF	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	mellitus type II right eye.	and legally blind in the					
	An admission Min Assessment dated Resident #69 had The MDS indicate recall all three wo was oriented to ye week. The MDS i frequently incontir program had not be admission to the f Resident #69 was An admission ass indicated Resident bowel or bladder. indicated this resid toileting. An assessment for dated 08/19/11 ind "Occasionally In bowel" A current recapitu physician's order of "Furosemide 80 tablet orally once A current Medicat (MAR) dated for S Resident #69 rece	imum Data Set (MDS) d 08/25/11, indicated severely impaired vision. d Resident #69 was able to rds given in assessment and ear, month and day of the indicated Resident #69 was nent of urine and a toileting been attempted since racility. The MDS indicated receiving a diuretic. ressment dated 08/19/11 at #69 was not continent of The admission assessment dent required supervision for or bowel and bladder training dicated Resident #69, recontinent [sic]Continent of lation with a current dated 08/19/11 indicated, rmg [water pill] tablet give 1 a day" ion Administration Record September 2011, indicated, eived Furosemide 80 mg at ay 09/01/11 through					
		ed 08/20/11 at 1:00 p.m., It #69 wears a brief and was es.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPI	ETED
		155711	B. WING			09/16/2	011
				_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEI	R		2926 N	ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALT	HCARE			APOLIS, IN46208		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ted 08/24/11 at 12:00 p.m., at #69 voided while in the					
		and was assisted with					
	pericare and char						
		3 3					
		ed 09/02/11, untimed,					
		nt #69 has episodes of					
	incontinence.						
	During on the	otion on 00/12/2011 of					
		ation on 09/12/2011 at lent #69 pants were wet in					
		thighs. Resident #69 was in					
		resident's room during					
	initial interview.	J					
		ation 09/13/11 at 1:12 p.m.,					
		s leaving the dining room					
		hall with a walker. The back horts were wet over					
	buttocks area.	monts were wet over					
	A Social Service F	Progress note dated					
		(5:41 p.m.) indicated, "Very					
		ly after lunchhad					
		ne incontinent after eating					
	and was quite dis	traught"					
	On 09/14/11 at 25	45 p.m., care plans, activity					
		service notes were					
		e Social Service Director					
	(SSD).						
		sident #69 were provided by					
	the SSD on 09/14	4/11 at 4:30 p.m.					
	The most recent of	care plans for Resident #69					
		/11 and were reviewed on					
	09/15/11 at 12:50						
		d documentation of an					
	incontinence care	pian.					
	<u> </u>						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155711	A. BUII B. WIN			09/16/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	2					
	UD MANOD LIEALT	HOADE		1	ORTH CAPITOL AVENUE		
HIGHLAI	HIGHLAND MANOR HEALTHCARE			INDIAN	APOLIS, IN46208		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	During an intervier Resident #69 indiction schedule. I'm getting a water During an intervier LPN #5 indicated toileting program. encouraged the reafter meals. LPN # likes to sit down frowear a brief. LPN gets embarrassed episode. During an intervier CNA #3 indicated the facility with pelarge) and wore twindicated Residen incontinent. CNA is out of personal depends are being properly. CNA #3 Nursing (DoN) was A facility policy pro 09/16/11 at 8:30 a indicated, "Policy: to create, review at that addresses the problems, specific *Initiate a plan of oproblems as they RAPs [Resident Athe MDS [Minimur]	w on 09/15/11 at 10:28 a.m., cated there was not a Resident #69 indicated, "I pill in the evening." w on 09/15/11 at 12:57 p.m., Resident #69 was not on a LPN #5 indicated the staff esident to toilet before and #5 indicated, Resident #69 ront and doesn't always at #5 indicated Resident #69 in the indicated Resident #69 in the indicated Resident in the indicated Resident in the resident was admitted to resonal briefs size 2X (extra wo at a time. CNA #3 in the resident Resident #69 briefs; therefore, the facility gused and do not fit indicated the Director of informed. Devided by the DoN on in.m., titled, "Care Plan," It is the policy of the facility and update a plan of care			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
		Il specific to the identified					
		rmulate related approaches					
	to reach the goal						
	problem/need *da	ate the reviews as done and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711			(X2) MUL A. BUILDI		OO	(X3) DATE S COMPL	ETED
		100711	B. WING			09/16/2	011
NAME OF P	ROVIDER OR SUPPLIER				ODRESS, CITY, STATE, ZIP CODE		
HIGHLAN	ID MANOR HEALTI	HCARE			POLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES	l	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	l	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
TAG		as participating *identify		IAG	DLI ICILICE I		DATE
	the responsible disapproach *review quarterly or as sign *invite the resident resident/family una care plan by phone *update care plan review if applicable plan throughout th	sciplines involved for each the care plan monthly, nificant changes occur to the desired (if able to attend, review the e or in person if so desired) dates and problems each e *maintain the active care e admission Responsible ng, MDS, Social Service,					
F0282 SS=G	facility must be proin accordance with plan of care. Based on obse record review the follow physician needed pain mecare, and the facof care for a reside	ded or arranged by the ovided by qualified persons a each resident's written arvation, interview and the facility failed to assessed to be f2 residents in a stage two	F028	32	Same as F 279All residents have potential to be affected. Oplans have been reviewed for residents with participation of care givers to identify needs/concerns/problems in effort to have a complete and accurate POC for each reside Changes in MD orders are	Care r all · all an	09/26/2011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155711	A. BUII			09/16/2	011
			B. WIN				
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALT	HCARE		INDIAN	APOLIS, IN46208		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sample of 25. (#2	6) (#69)			reviewed daily by DON for		
					problems requiring update or	ו	
	Findings include:				POC for specified residents.		
	1 The record for	Resident #69 was reviewed			MDS coordinator will initiate		
	on 09/14/11 at 8:5				plan on admission identifying problems then gernerate	two	
	011 03/1 1 /11 at 0.0	ou a.m.			additional from triggered iten	ns on	
	Diagnoses include	ed, but were not limited to			MDS. Information from resid		
		auditory hallucinations, high			interviews is also incorporate		
		ty, agitation, schizoaffective			the POC as indicated. All		
		olled diabetes mellitus type II			disciplines are responsible.		
	and legally blind in	n the right eye.			monitors updates during revi		
					new MD orders daily and we	•	
	An admission Min	imum Data Set (MDS)			in care plan conferences with		
	Assessment date	d 08/25/11, indicated			individual residents. Review		
		severely impaired vision.			monthly 3x then quarterly 3x	ın	
		ed Resident #69 was able to			QA. Completed 9/26/11 and		
		rds given in assessment and			on-going.		
		ear, month and day of the					
		ndicated Resident #69 was					
		nent of urine and a toileting					
		peen attempted since					
		acility. The MDS indicated receiving a diuretic.					
	Resident #09 was	receiving a didretic.					
	An admission ass	essment dated 08/19/11					
		it #69 was not continent of					
		The admission assessment					
		dent required supervision for					
	toileting.	dent required eaperviolen let					
	An assessment fo	r bowel and bladder training					
	dated 08/19/11 in	dicated Resident #69,					
	· ·	continent [sic]Continent of					
	bowel"						
	· ·	lation with a current					
		dated 08/19/11 indicated,					
		mg [water pill] tablet give 1					
	tablet orally once	a uay					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	MMC	00	COMPL	ETED
		155711	B. WING			09/16/2	011
		<u> </u>	B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ORTH CAPITOL AVENUE		
нісні лі	ND MANOR HEALT	HCVDE			APOLIS, IN46208		
HIGHLA	ND MANOR HEALT	HOARE		INDIAN	AFOLIS, IN40208		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	P.	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ion Administration Record					
	l ' '	September 2011, indicated,					
		eived Furosemide 80 mg at					
	9:00 a.m. everyda 09/15/11.	ay 09/01/11 through					
	09/15/11.						
	A nurses note dat	ed 08/20/11 at 1:00 p.m.,					
		nt #69 wears a brief and was					
	incontinent at time						
	A nurses note dat	ed 08/24/11 at 12:00 p.m.,					
	indicated Residen	t #69 voided while in the					
	main dining room	and was assisted with					
	pericare and char	nging clothes.					
	l .	1.00/00/44					
		ed 09/02/11, untimed,					
		t #69 has episodes of					
	incontinence.						
	During an observa	ation on 09/12/2011 at					
		ent #69's pants were wet in					
		thighs. Resident #69 was in					
		her room during an initial					
	interview.						
		ation on 09/13/11 at 1:12					
	1 ' '	9 was leaving the dining					
		n the hall with a walker.					
		esident's shorts were wet					
	over lower buttocl	ns alca.					
	A Social Sociator	Progress note dated					
		(5:41 p.m.) indicated, "Very					
		ly after lunchhad					
		ne incontinent after eating					
	and was quite dis						
	, , , , ,	-					
		45 p.m., care plans, activity					
		service notes were					
		e Social Service Director					
	(SSD).						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		A. BUII	LDING	NSTRUCTION 00	(X3) DATE (COMPL 09/16/2	ETED	
		100711	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/10/2	011
NAME OF I	PROVIDER OR SUPPLIER	8			ORTH CAPITOL AVENUE		
HIGHLAN	ND MANOR HEALT	HCARE		1	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		,		mo			DATE
	Care plans for Re the SSD on 09/14	sident #69 were provided by /11 at 4:30 p.m.					
		eare plans for Resident #69 /11 and were reviewed on p.m.					
	The record lacked incontinence care	documentation of an plan.					
	Resident #69 indictoileting schedule.	w on 09/15/11 at 10:28 a.m., cated there was not a Resident #69 indicated, "I pill in the evening."					
	LPN #5 indicated toileting program. encouraged the reafter meals. LPN ilikes to sit down from the site of the site	w on 09/15/11 at 12:57 p.m., Resident #69 was not on a LPN #5 indicated the staff esident to toilet before and #5 indicated, Resident #69 ront and doesn't always #5 indicated Resident #69 If she has an incontinent					
	CNA #3 indicated the facility with pe large) and wore twindicated Residen incontinent. CNA is out of personal briefs are being us	w on 09/15/11 at 2:52 p.m., the resident was admitted to rsonal briefs size 2X (extra vo at a time. CNA #3 t #69 goes "a lot" when #3 indicated Resident #69 briefs; therefore, the facility sed and do not fit properly. the Director of Nursing ed.					
	09/14/11 at 9:25 A were not limited to amputation, debili	record was reviewed on a.M Diagnoses included but be left above the knee ty, CVA (cerebrovascular ypertension), dementia with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155711	B. WING			09/16/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	t .			ORTH CAPITOL AVENUE		
нісні ли	ID MANOD HEALT	HCARE			APOLIS, IN46208		
HIGHLAI	HIGHLAND MANOR HEALTHCARE			INDIAN	AFOLIS, IN40208		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
	agitation, and psy	chosis.					
	05/17/11, indicate of 6, did not ambudependent on state eating, toileting, p mobility. Resident limitation on both extremities.	n Data Set (MDS) dated d resident had a BIM score late, and was totally ff for locomotion, dressing, ersonal hygiene and bed had ROM (range of motion) sides of his upper and lower					
	resident had a Folor of bowel and was (activities of daily and grooming. The resident had controlleft elbow and a resident had a Folor of bowel and was a controlleft elbow and a Folor of bowel and was a controlleft elbow and a Folor of bowel and was a controlleft elbow and a Folor of bowel and was a controlleft elbow and a Folor of bowel and was a controlleft elbow and a Folor of bowel and was a controlleft elbow and a Folor of bowel and was a controlleft elbow and a Folor of bowel and a Folor of bowe	n dated 08/31/11, indicated ley catheter, was incontinent dependent for ADL's living), bathing, dressing, e care plan also indicated ractures of his left hand and ectal fistula. Interventions for ctal fistula included, a needed)"					
	indicated "Algisite dressingpack fis	s orders dated 06/04/11, M (wound dressing) 4"x 4" stula w/ (with) calcium once daily and PRN					
	indicated "Hydroc	orders dated 08/03/11, odone-APAP (pain mg (milligrams)give 1 8 hours"					
	indicated "Acetam 325 mg give 2 t	orders dated 06/24/2009, ninophen (pain medication) nablets (650 mg) PO (by nurs PRN (as needed)					
	at 10:40 A.M., with	ation of pericare on 09/14/11 n CNA #2, Resident #26 was l a bowel movement and					

PRINTED: 10/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711		A. BUILDI		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED 09/16/2011		ETED	
			B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ORTH CAPITOL AVENUE		
HIGHLAI	ND MANOR HEALT	HCARE			APOLIS, IN46208		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	ΓAG	DEFICIENCI)		DATE
	CNA #2 wiped the buttocks and fistu	tting in his rectal fistula. stool from the resident's la. The CNA indicated at sing was "somewhere in wound]."					
		CNA #2 on 09/14/11 at at at a she would inform the aident had a bowel					
	12:15 P.M., indica	CNA #2 on 09/14/11 at ted she had informed the nt #26 had a bowel					
	P.M., indicated CI the resident's bow she had not condu the wound at that	LPN #5 on 09/14/11 at 12:20 NA #2 had informed her of vel movement. She indicated ucted a dressing change of time. She indicated it was" and would be getting to er rounds.					
	09/14/11 at 1:45 F rectum and fistula packing was not of #5 cleansed the w the wound care, F in pain. The reside ouchmy hemorrh by saying, "[res na hemorrhoids, you #26 responded by difference it hus that time the resid medication prescr to receive his nex	wound care with LPN #5 on P.M., indicated resident's were covered in stool. The observed in the wound. LPN yound and packed it. During Resident #26 was yelling out ent indicated, "ouch ouch noids" The LPN responded ame] you don't have have a wound" Resident y saying, "what's the rts" LPN #5 indicated at lent had scheduled pain itbed and it was time for him t dose. She indicated ald receive the pain ne treatment was					

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Event ID:

862411

Facility ID:

000567

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155711		A. BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/16/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	P.M., indicated the between when the movement when to She indicated the and nursing may resident more ofter. A current undated "Physicians Order 09/16/11 at 8:30 Ato " assure all necarried out in a confidence of the procedure sets specify that physicians or the procedure sets specify that physician out as writed. A current undated Management" professes the facility and manage residuassess the resider pain medication as A current undated "Incontinence Mar DON on 09/16/11"policy: to ensure residents are cleatimesProcedure residents at least and after meals are	facility policy titled, s" provided by the DON onM., indicated the policy is ew physician orders are rect and timely manner". ction of the policy does not cians orders should be ten. facility policy titled, "Pain wided by the DON onM., indicated "it is the y to identify, assess, treat ent painProcedure: ntadminister prescribed is ordered" facility policy titled, nagement" provided by the at 9:00 A.M., indicated et that all incontinent in, dry and odor free at alltoilet incontinent every two (2) hours, before and hs (hour of biding times to be able to						

´		(X2) MULTIPLE CO	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155711	A. BUILDING	00	COMPLETED 09/16/2011		
		100711	B. WING	DDDEGG GITTY GTATE ZID GODE	09/10/2011		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE			
	ND MANOR HEALTI		INDIANAPOLIS, IN46208				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE		
F0309 SS=G	must provide the material to attain or maintain physical, mental, as in accordance with assessment and passed on observation interview, the facility received appropriation care, and pain material management in a surface of the facility of	tion, record review and ity failed to ensure residents ate dialysis care, wound nagement for 1 of 2 dialysis f 5 residents with wounds, ts reviewed for pain Stage 2 sample of 25 d #26). Resident #71 was reviewed 0 P.M. s included, but were not stomy, osteomylitis lower tension), DM (diabetes	F0309	All residents have the potent be affected. Pain manageme assessments are utilized for resident receiving pain medication. Wound care has been reviewed and treatmen revisions done as indicated. Dialysis resident charts have been reviewed to identify dia treatment orders. Lab result pre/past dialysis notes have requested from dialysis for edialysis patient. Wound rour are done weekly by wound nand DON. Effectiveness of treatments will be assessed least monthly for progress an needed revision if indicated. assessments, dialysis orders wound orders and other physorders will be reviewed for	ent each s s at elysis s, been ach nds nurse at nd Pain s,		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711	
NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
NAME OF PROVIDER OR SUPPLIER HIGHLAND MANOR HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
HIGHLAND MANOR HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
PREFIX (FACH DEFICIENCY MIST BE PERCEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
orders lacked an order for the resident to go compliance weekly through audits	
to a dialysis center for dialysis. An order, by DON. Charge nurses are	
dated 8/18/11, indicated Resident #71 was to responsible. DON will monitor receive Midodrine 10 mg (milligrams) 3 days a through documentation audits	
week on Tuesday, Thursday, and Saturday weekly. Findings will be	
before dialysis, which was the only mention of monitored monthly 3x and then	
dialysis in the physicians orders. quarterly 3x in QA. Completed	
9/26/11 and on-going.	
The Nurses Notes indicated Resident #71	
went to dialysis on 8/30/11, 9/1/11, 9/8/11,	
9/10/11, 9/13/11 and 9/15/11. The record	
lacked documentation of pre/post dialysis	
weights, B/Ps, documentation from the	
dialysis center, or that he had returned from	
dialysis.	
During an interview with LPN #4 on 9/16/11 at	
10:10 A.M., she indicated the dialysis center	
had never sent any paper work back with him.	
2. Resident #26's record was reviewed on	
09/14/11 at 9:25 A.M Diagnoses included but	
were not limited to left above the knee	
amputation, debility, CVA (cerebrovascular	
accident), HTN (hypertension), dementia with	
agitation, and psychosis.	
A gurrent Minimum Data Cat (MDC) datad	
A current Minimum Data Set (MDS) dated 05/17/11, indicated resident had a BIM score	
of 6, did not ambulate, and was totally	
dependent on staff for locomotion, dressing,	
eating, toileting, personal hygiene and bed	
mobility. Resident had ROM (range of motion)	
limitation on both sides of his upper and lower	
extremities.	
A current care plan dated 08/31/11, indicated	
resident had a Foley catheter, was incontinent	
of bowel and was dependent for ADL's	
(activities of daily living), bathing, dressing, and grooming. The care plan also indicated	
and grooming. The care plan also indicated	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155711 09/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2926 NORTH CAPITOL AVENUE HIGHLAND MANOR HEALTHCARE INDIANAPOLIS, IN46208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE resident had contractures of his left hand and left elbow and a rectal fistula. Interventions for the care of the rectal fistula included. "pericare PRN (as needed)..." Current physicians orders dated 06/04/11, indicated "Algisite M (wound dressing) 4"x 4" dressing...pack fistula w/ (with) calcium alginate. Change once daily and PRN soilage..." Current physician orders dated 08/03/11. indicated "Hydrocodone-APAP (pain medication)5-500 mg (milligrams)...give 1 tablet orally every 8 hours..." Current physician orders dated 06/24/2009, indicated "Acetaminophen (pain medication) 325 mg ... give 2 tablets (650 mg) PO (by mouth) every 4 hours PRN (as needed) pain..." During an observation of pericare on 09/14/11 at 10:40 A.M., with CNA #2, Resident #26 was noted to have had a bowel movement and some stool was sitting in his rectal fistula. CNA #2 wiped the stool from the resident's buttocks and fistula. The CNA indicated at that time the dressing was "...somewhere in there...[inside the wound]." An interview with CNA #2 on 09/14/11 at 10:55 A.M., indicated she would inform the nurse that the resident had a bowel movement. A pain assessment dated 12/8/10, indicated, "...Resident is capable of reporting presence or absence of pain..." No check marked. "...Resident reports presence of pain..." Yes check marked. "...Resident exhibits behaviors

indicative of pain..." No check marked...The

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155711 09/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2926 NORTH CAPITOL AVENUE HIGHLAND MANOR HEALTHCARE INDIANAPOLIS, IN46208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
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CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE assessment has a hand written note on the bottom of the page signed by the DON dated 06/08/11 that indicated, "...no c/o (complaints of) or evidence of a pain/assessment...." An interview with CNA #2 on 09/14/11 at 12:15 P.M., indicated she had informed the nurse that Resident #26 had a bowel movement. An interview with LPN #5 on 09/14/11 at 12:20 P.M., indicated CNA #2 had informed her of the resident's bowel movement. She indicated she had not conducted a dressing change of the wound at that time. She indicated it was her "...wound day..." and would be getting to the resident on her rounds. An observation of wound care with LPN #5 on 09/14/11 at 1:45 P.M., indicated resident's rectum and fistula were covered in stool. The packing was not observed in the wound. LPN #5 cleansed the wound and packed it. During the wound care, Resident #26 was yelling out in pain. The resident indicated, "...ouch ouch ouch..my hemorrhoids..." The LPN responded by saying, "[res name] you don't have hemorrhoids, you have a wound...." Resident #26 responded by saying, "what's the difference ... it hurts..." LPN #5 indicated at that time the resident had scheduled pain medication prescribed and it was time for him to receive his next dose. She indicated Resident #26 would receive the pain medication after the treatment was completed. An interview with LPN #5 on 09/14/11 at 3:15 P.M., indicated there was a long time span

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between when the resident had a bowel

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155711	A. BUILDING	00	09/16/2011
		100711	B. WING	A DDDEGG CITY GTATE ZID CODE	03/10/2011
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE	
HIGHLAN	ND MANOR HEALTI			APOLIS, IN46208	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		· · · · · · · · · · · · · · · · · · ·	TAG	DEFICIENCY)	DATE
	She indicated the and nursing may n resident more ofte	ne dressing was changed. resident has frequent stools leed to check on the n. facility policy titled,			
	"Physicians Orders 09/16/11 at 8:30 A to " assure all ne carried out in a con The procedure sec	s" provided by the DON on .M., indicated the policy is w physician orders are rrect and timely manner". ction of the policy does not cians orders should be			
	Management" provided assess the resider pain medication as A current undated "Dialysis" provided access for the dial treatment as order centerall recommiste for corrective a addressedweigh	facility policy titled, I by the DON on 09/16/11 at ed, "Policy: to provide ysis resident to receive ed by the dialysis nendations from the dialysis			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711			(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 09/16/2	ETED
	PROVIDER OR SUPPLIER		•	2926 NO	DDRESS, CITY, STATE, ZIP CODE DRTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0322 SS=D	a resident, the factoresident who is fed gastrostomy tube treatment and service pneumonia, diarrh metabolic abnormasal-pharyngeal possible, normal ed Based on observation of a water flushes we facility policy for observation of a water flushes we facility policy for observation of a water flushes we facility policy for observation of a water flushes we facility policy for observation of a water flushes we facility policy for observation of a water flushes we facility policy for observation of a water flushes we facility policy for observation of a water flushes we facility policy for observation of a water flushes we facility policy for observation of a water flushes we facility policy for observation, placed for the record for Res 9 /14/11 at 9:05 A. Current diagnoses limited to, traumate schizophrenia, attoretardation). HTN constipation, hypocation constitution, hypocation of placed flushes for the current recapion of the cur	ulcers and to restore, if lating skills. Action, record review and cility failed to ensure re done according to r 1 of 1 G/T (gastrostomy) for flush in a Stage 2 sample of MA#6). Sident #30 was reviewed on M. Sincluded, but were not ic subdural hematoma, any of bladder, MR (mental (hypertension), thyroidism, dyslipidemia, there y disease). Stullation of physician's resident #30 was to receive of water as a flush through	F03	322	All residents have the potent be affected. The QMA has be re-trained on G-tube flushes. Compliance will be monitored charge nurse during the med pass. Charge nurses are responsible for assuring the dis proficient in the procedure. DON will monitor at least one G-tube flush weekly as well at the proficiency of the QMA. Findings will be reviewed mo 3x and quarterly 3x in QA. Re-training will be done as needed to ensure accuracy of procedure. Completed 9/26/1 and on-going.	een d by QMA ee as inthly	09/26/2011

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155711		(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE S	ETED	
		155711	B. WIN	_		09/16/2	011
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
HIGHLA	ND MANOR HEALT	HCARE			ORTH CAPITOL AVENUE APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΤE	COMPLETION
TAG		ater up into an asepto	-	TAG	DEFICIENCE		DATE
	syringe, placed it in plunged the water (70 ml) of the water the tube by gravity through the syring	into the end of the G/T and down the tube. The rest er was allowed to flow into y. Air had not been plunged the as QMA #6 listened to the distomach content been					
	Director and Director 9/14/11 at 4:45 P.	ce with the Executive etor of Nursing (DON) on M., the DON indicated this buld have been done.					
	provided by the D	olicy, dated 7/20/10, ON on 9/15/11 at 9:05 A.M., ng medication via G or J e" indicated:					
	aspirate from the aspirating with the	entify bowel sounds as you tube. Measure residual by					
	The record for Re 9 /14/11 at 9:05 A	sident #30 was reviewed on .M.					
	limited to, traumat schizophrenia, ato retardation). HTN	thyroidism, dyslipidemia,					
	orders indicated F	itulation of physician's Resident #30 was to receive of water as a flush through day.					
	The record for Re	sident #30 was reviewed on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155711	B. WING	NO .		09/16/2	011
				TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ORTH CAPITOL AVENUE		
HIGHLAND MANOR HEALTHCARE		HCARE			APOLIS, IN46208		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	9 /14/11 at 9:05 A.	M.					
	Current diagnoses included, but were not limited to, traumatic subdural hematoma, schizophrenia, atony of bladder, MR (mental retardation). HTN (hypertension), constipation, hypothyroidism, dyslipidemia, CAD (coronary artery disease). The current recapitulation of physician's orders indicated Resident #30 was to receive 100 ml (milliliters) of water as a flush through the G/T 3 times a day. 3.1-44(a)(2)						
F0371 SS=F	considered satisfa local authorities; a (2) Store, prepare under sanitary cor Based on obse the facility failed sanitary mannel laminated reside gloved hand ar lunch without chad the potenti residents who refacility kitchen. Findings include During a lunch	distribute and serve food diditions rvation and interview do to serve food in a ser by a cook touching lent meal cards with a lend then plating food for hanging gloves which all to effect 43 of 43 receive meals from the (Cook #1)	F0371	1	All residents have the potenti be affected. Policy and Proce on food handling reviewed by Dietician. All kitchen staff in-serviced on proper food storage, preparation, and ser technique and procedure on 9/21/11. One on One re-trair completed for kitchen staff lacking observable skill set in sanitary food service procedures. Dietary Manager Charge cooks are responsibl monitoring. Errors will be immediately corrected and identified for re-training. Findings will be reviewed with	edure / rve ning r and e for	09/21/2011

PRINTED: 10/12/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	(X2) MU A. BUII B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 09/16/2	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	donned gloves food using serving ladles. laminated residual proceeded to wedge on residual same gloved hands. Cook the service line placed the slice into the service line placed the slice into the serving continued to us plate and served. During an inter 1:00 p.m., the lindicated Cook touched laminaresident food whands. The DN meal cards in hinterview on the station. On 09/15/11 at kitchen policy or requested from Nursing and the serving services of the ser	and started plating ving scoops and Cook #1 handled dent meal cards. Cook to serve a lemon dent plates with the ands. Cook #1 wiped he back of the gloved k #1 continued to serve with the same gloved #1 removed a slice of a a resident's plate in a before served and to of cornbread back g pile. Cook #1 se the same gloves to be food. View on 09/15/11 at Dietary Manager (DM) a #1 should not have atted meal cards and with the same gloved 1 had several laminated for hand during this are unit at the nurse's 15:30 p.m. a facility on food handling was a the Director of a Executive Director. 8:30 a.m. no facility			Dietician and QA monthly 3x quarterly 3x. Completed 9/2 and on-going.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

862411

Facility ID:

000567

If continuation sheet

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AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/16/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
F0458 SS=E	feet per resident in bedrooms, and at single resident rooms. Based record revolution, the resident bedroom square feet per resident bedrooms affect 12 of 12 resident these rooms. (Roand 27). Findings include A review of the find Sheet", dated 9/1 numbered 19, 20 listed as certified. During the entrangement of the state of the	least 100 square feet in oms. iew, interview and facility failed to ensure as measured at least 80 esident for 6 of 28 rooms. actice had the potential to esidents who resided in from # 19, 20, 22, 25, 26	F0458	This facility request a room s waiver for rooms #19,20,22,25,26,27.	ize 09/19/2011		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711			LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/16/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	,	b. WIN		DDRESS, CITY, STATE, ZIP CODE		
					ORTH CAPITOL AVENUE		
	ND MANOR HEALT			<u> </u>	APOLIS, IN46208		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	(sq. ft.) per resid	ent. All identified bed					
	contained two beds.						
	During an interv	iew with the					
	Administrator at	that time, he indicated					
		nged and the rooms were					
	still being utilize	ed the same way.					
	Review of facility n	neasurements for resident					
	rooms numbers 19, 20, 22, 25, 26 and 27, indicated the bedrooms lacked 80 sq. ft. per resident. All identified rooms contained two beds.						
	Room number, number of beds, total square feet per room and square feet per bed were as follows:						
	*19 - 2, 153.38 sq. 1	ft 76 69 sa ft					
	*20 - 2, 142.46 sq. 1						
	*22 - 2, 142.09 sq. 1						
	*25 - 2, 157.01 sq. 1						
	*26 - 2, 145.93 sq. t *27 - 2, 154.65 sq. t						
	-	i., 77.33 sq. ii.					
	3.1-19(1)						
	3.1-19(2)						
	3.1-19(3)						
	3.1-19(4)						
	3.1-19(8)						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
155711		155711	A. BUILDING		09/16/2	011	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ORTH CAPITOL AVENUE		
HIGHLAND MANOR HEALTHCARE					APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(V5)
			PREFIX (EACH)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
	`			CROSS-REFERENCED TO THE		E	DATE
F0498 SS=G	The facility must e able to demonstrate chniques necess needs, as identifie assessments, and care. Based on observate facility failed to ensemble of 25 (Research end	cord was reviewed on i.M Diagnoses included but beleft above the knee ty, CVA (stroke), HTN imentia with agitation, and in Data Set (MDS) dated different #26 had a BIMS mental status) score of 6 impairment), did not is totally dependent on staff tessing, eating, toileting, and bed mobility. Resident inge of motion) limitation on inpper and lower extremities. in dated 08/31/11, indicated the Foley catheter, was tel and was dependent for	F0	PREFIX TAG	All residents have the potenti be affected. A skills check for CNAs to identify additional training needs. Care in-servi are conducted for CNAs at le monthly. Skills check will be conducted at least monthly. Charge nurses are responsil DON will monitor on daily wa rounds and review of check I Findings will be reviewed mo 3x and then quarterly 3x in QA. Completed 9/26/11 and on-going.	al to or all ces ast ble. lking ist.	O9/26/2011
	ADL's (activities of dressing, and groot indicated resident	f daily living), bathing, oming. The care plan also #26 had contractures of his elbow and a rectal fistula.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		155711	A. BUILDING	00	09/16/2011	
		100711	B. WING	ADDRESS CITY STATE ZID CODE	00/10/2011	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE		
HIGHLAND MANOR HEALTHCARE				APOLIS, IN46208		
(X4) ID	SHMMARV S	TATEMENT OF DEFICIENCIES	ID ID	<u> </u>	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	
		•				
	During an observa	tion of pericare on 09/14/11				
	· ·	A #2, pulled the covers off				
		Resident was nude under				
		2 roughly grabbed the				
		and started roughly a wet soapy washcloth.				
	_	sticles were very red and				
		A #2 washed the testicles,				
		d yelling, "ouch your				
	hurting my ballss	stopthat hurts." CNA #2				
		ng, "sorry, but I gotta clean				
		en grabbed Resident #26's				
		arted roughly washing the ey catheter. The resident				
		ouch your hurting my				
		e CNA again responded by				
		ve got to clean this". The				
		rubbing the resident nor did				
	she reduce the am	nount of force she was using				
		stated he was in pain. CNA				
		ident #26 over. The				
		vel movement and some his rectal fistula. His				
	•	oriated. CNA #2 used a dry				
		wiping Resident #26's				
		I area. The resident started				
		hurtsyou know I have				
	hemorrhoids stop.					
		IA #2 responded by saying,				
	•	emorrhoids you have a as stool visible in the rectal				
		CNA did not reduce the				
	•	or the amount of force she				
		ne resident stated he was in				
	pain. The CNA turn	ned the resident over on to				
		completely exposed. The				
		m cold, cover me up." The				
		ver you up when I'm				
		The CNA repositioned				
		then grabbed a washcloth tracted left hand. CNA #2				
	to place in the con	Casta for fiana. Of the				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DINI DING 00		00	COMPLETED	
		155711	A. BUILDING		09/16/2	011	
			B. WIN		DDDEGG CITY GTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
				1	ORTH CAPITOL AVENUE		
HIGHLAI	ND MANOR HEALT	HCARE		INDIAN	APOLIS, IN46208		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	told the resident to	o relax and started to push	İ				
	the washcloth into	the resident's hand. The					
		yell, "you are killing					
		uch ouchstop you are					
		The CNA told the resident if					
		dn't hurt as much as she					
	· ·	the washcloth into his hand.					
		d again, "stopyou know I					
		tis)ouch ouch" The each up with his other hand					
	and stop the CNA but could not reach her. The CNA did not stop until the washcloth was in his hand. The resident indicated his hand						
	hurt, and the CNA responded, "its going to hurt for a little bit." The CNA left the resident nude and then covered the resident up and left the room.						
	An interview with CNA #2 on 09/14/11 at						
		ited she was going to go					
		n to put some cream on his					
		cated that she would inform					
		resident had a bowel					
	movement. An interview with CNA #2 on 09/14/11 at 12:15 P.M., indicated she had put cream on the resident's testicles. The CNA indicated, the resident always screams like that during						
	,	cated, "I just tell him to					
		en I was putting the					
	washcloth in his hand"						
		I documentation of how the					
	resident tolerated	perineal care.					
		klist provided by the DON on					
		A.M., indicated CNA's are to					
		factory skills in pericare,					
	and in bathing de	pendent residents.					
	,	6. 99					
	A current undated	facility policy titled,					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED				
		155711	B. WING		09/16/2	011		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
HIGHLAND MANOR HEALTHCARE			2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208					
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)		
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E RIATE	COMPLETION		
TAG			TAG	DEFICIENCY)		DATE		
TAG	"Perineal Care" pro 09/16/11 at 8:30 A procedure12. For lower part of the be- with a sheet13. If pajamas. Avoid un resident's body1 residentwash pe- urethra and working perineum following sequenceReport Documentationthe should be reported and should be documedical record4. bleeding, skin irritated discomfort5. Pro- urethral-catheter jusuch as drainage, crusting or pain6 the procedure or a	rineal area starting with ag outwardd. Gently dry g same ting and the following information of to the staff/charge nurse tumented in the resident's and Any discharge, odor, ation, complaints of pain or blem noted at the function during perineal care redness, bleeding, irritation, b. How the resident tolerated	TAG	DEFICIENCY)	(KALE	DATE		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155711	A. BUILDING B. WING	00	COMPI 09/16/2	LETED
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ORTH CAPITOL AVENUE	1	
HIGHLAND MANOR HEALTHCARE				APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	on BE PRIATE	(X5) COMPLETION DATE